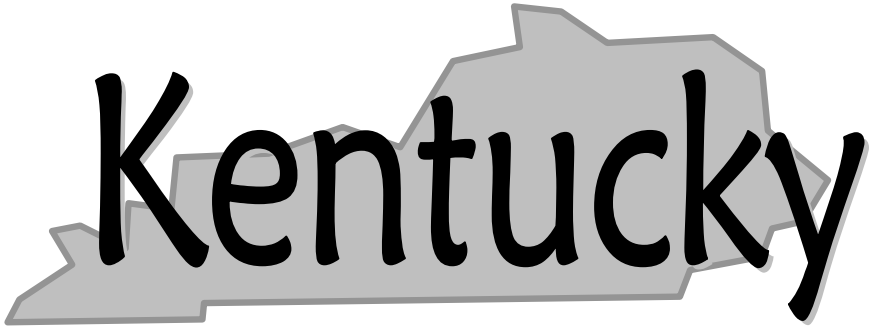
2010 ANNUAL SURVEY OF LICENSED AMBULATORY SURGICAL SERVICES



January 1, 2010 - December 31, 2010

CABINET FOR HEALTH AND FAMILY SERVICES
OFFICE OF HEALTH POLICY
275 EAST MAIN STREET 4 W-E
FRANKFORT, KY 40621

Completion required by 902 KAR 20:008, (rev 10-15-03)and 900 KAR 6:125

2010 ANNUAL SURVEY OF LICENSED AMBULATORY SURGICAL SERVICES

INTRODUCTION

This survey is for the reporting period: **January 1, 2010 through December 31, 2010.** The data requested in this document represent data requirements approved by the Cabinet for Health and Family Services as set forth in 902 KAR 20:008 (rev. 10-15-03) and 900 KAR 6:125.

The Annual Ambulatory Surgical Services survey is now required to be completed and submitted via the internet. Please submit on the following website: **https://apps.chfs.ky.gov/OHPSurvey/Default.aspx**. Please note that a new section has been added to the survey. Procedure room data is now part of the survey. Section I collects data for ambulatory surgery performed in an OR and Section II collects procedure room data.

The accuracy and completeness of the data reported in this survey are very important. Therefore, all appropriate items must be completed before this survey will be considered acceptable. Please read all instructions carefully and thoroughly. Compare this survey to surveys previously submitted online for consistency and comparability.

The survey is due by March 15, 2011. Any survey found to have errors or omissions may not be accepted and can cause your facility to be considered out of compliance with 902 KAR 20:008 (rev. 10-15-03) and 900 KAR 6:125 until you have reported complete and correct data. Facilities that are found to be out of compliance will be referred to the Office of the Inspector General for possible licensure deficiencies.

Beth Morris is the primary contact person for this survey. The telephone number for the Office of Health Policy is (502) 564-9592 or email betha.Morris@ky.gov.

The annual reporting period for this survey: **January 1, 2010 through December 31, 2010**.

DEFINITIONS

In all instances, unless otherwise specified, the terms used in this survey are the same as those found in the American Hospital Association AHA Hospital Statistics, 2005 Edition,

2010 ANNUAL SURVEY OF LICENSED AMBULATORY SURGICAL SERVICES
January 1 through December 31, 2010
Ambulatory Surgery Data

Do not leave any item blank. If the service or procedure is not provided, please use a zero. Include only Ambulatory Surgical Operations that have been performed in an operating room. Please indicate the number of ambulatory surgery operations performed by major service category.

Total Surgical Hours are defined as the time that the operating room was in actual use. Do not include scheduled time, available time, and/or clean-up time. **Average Clean Up** time between operations is reported in minutes.

Section I: Ambulatory Surgery Data

Service Report for: 1/1/10 through 12/31/10	Number of 2010
A. AMBULATORY SURGICAL OPERATIONS *(excluding heart) *****Defined as discrete patient encounters, whether major or minor, performed only in the operating room(s). A surgical operation can involve one or more surgical procedures, but is still considered only one operation. Unless specific procedures are asked for, operations should be reported. Endoscopic Surgery should include but not limited to the following; Laparoscopy, Thoracoscopy, Rhinoscopy, Otoscopy, Cystoscopy and Colonoscopy. Only include those that are invasive and performed in an ambulatory OR.	
1. Orthopedic surgery	
2. Plastic surgery	
3. ENT surgery	
4. Ophthalmological surgery	
5. Urologic surgery	
6. Gynecological surgery	
7. Endoscopic surgery (not included above in 1 - 6)	
8. All Other Surgery (Adult & Pediatric) *Do not include non-surgical procedures such as, blood transfusions, casts, & OR preparation. Report nonsurgical procedures in Section D.	
Total Ambulatory Surgery Operations (add lines A1 through A8)	
B. UTILIZATION - CAPACITY	

Service Report for: 1/1/10 through 12/31/10	Number of 2010
* Number of current OR's for your facility (if the actual number varies, please provide an explanation)	
1. Number of **Ambulatory** Operating Rooms (Exclusive Ambulatory Use)(Excluding Cystoscopy Rooms)	
2. Number of Cystoscopy Rooms	
3. Number of Patients Served during the Reporting Period	
4. Total Number of Hours/Typical Week Your Facility was Open	
C. SERVICE TIME	
1. **Total** Surgical Hours (REPORT IN WHOLE HOURS)	
2. **Average** clean-up time between operations (REPORT IN WHOLE MINUTES)	
D. NONSURGICAL PROCEDURES	
All Non-surgical Procedures Include any procedure in an operating room, which is not classified by your facility as surgical to be non-surgical.	
E. Number of pain management <u>cases</u> performed in an ambulatory OR. (Please list types of pain management procedures in comment box.)	

IF LESS THAN TWELVE (12) MONTHS, GIVE BEGINNING AND ENDING DATE OF OPERATION: _____

Comments: _____
_____

2010 ANNUAL SURVEY OF LICENSED AMBULATORY SURGICAL SERVICES
January 1 through December 31, 2010
Procedure Room Data

Do not leave any item blank. If the service or procedure is not provided, please use a zero. Include only Ambulatory Surgical Procedures that have been performed in a procedure room, not in an operating room. Please indicate the number of ambulatory surgical procedures performed by major service category.

Total Procedure Hours are defined as the time that the procedure room was in actual use. Do not include scheduled time, available time, and/or clean-up time. **Average Clean Up** time between procedures should be reported in minutes.

Section II: Procedure Room Data

Service Report for: 1/1/10 through 12/31/10	Number of 2010
A. AMBULATORY PROCEDURES *(excluding heart) *****Defined as discrete patient encounters, whether major or minor, performed only in the procedure room(s). A surgical procedure can involve one or more procedures, but is still considered only one operation. Unless specific procedures are asked for, the number of operations should be reported. Endoscopic Surgery should include but not be limited to the following; Laparoscopy, Thoracoscopy, Rhinoscopy, Otoscopy, Cystoscopy and Colonoscopy. Only include those that are performed in a procedure room.	
1. Orthopedic surgical procedure	
2. Plastic surgical procedure	
3. ENT surgical procedure	
4. Ophthalmological surgical procedure	
5. Urologic surgical procedure	
6. Gynecological surgical procedure	
7. Endoscopic surgical procedure (not included above in 1 - 6)	
8. All Other Surgical Procedures (Adult & Pediatric) *Do not include non-surgical procedures such as, blood transfusions, casts, & OR preparation. Report nonsurgical procedures in Section D.	
Total Ambulatory Surgical Procedures (add lines A1 through A8)	

Service Report for: 1/1/10 through 12/31/10	Number of 2010
B. UTILIZATION - CAPACITY	
1. Number of **Ambulatory** Procedure Rooms (Excluding Cystoscopy Rooms) as of December 31, 2010	
2. Number of Endoscopy Rooms if not included in number of Ambulatory Procedure Rooms?	
3. Number of Patients Served in a procedure room during the reporting period	
4. Total number of hours/typical week the procedure room was operational?	
C. SERVICE TIME	
1. **Total** Procedure Hours (REPORT IN WHOLE HOURS)	
2. **Average** clean-up time between procedures (REPORT IN WHOLE MINUTES)	
D. PROCEDURES	
All non-surgical procedures performed in a procedure room. Include any procedure in an procedure room, which is not classified by your facility as surgical to be non-surgical.	
E. Number of pain management <u>cases</u> performed in procedure room. (Please list types of pain management procedures in the comment box.)	

IF LESS THAN TWELVE (12) MONTHS, GIVE BEGINNING AND ENDING DATE OF OPERATION: _____

Comments: _____
_____

CERTIFICATION OF DATA

On behalf of the administration of (Facility), I certify that the information contained in this report is complete and accurate. After reviewing the information contained in this report, I hereby submit it as an official record of the facility's activity in compliance with 902 KAR 20:008 (rev. 10-15-03) and 900 KAR 6:125.

Signed _____ Date _____

Title_____

Phone_____ Email Address_____

SPECIAL NOTE: Policies regarding data submission and changes to data can be reviewed on the OHP web site: http://chfs.ky.gov/ohp/. By signing you are certifying this data is correct. The Ambulatory Surgical survey is required to be submitted on the following website: **https://apps.chfs.ky.gov/OHPSurvey/Default.aspx**. Paper copies of the survey are no longer accepted as an official submission of the required data.

NOTICE: Please review the data entered on this survey. Check that all questions have been answered accurately and in full. Refer to the instructions for each section if you have any questions. If any part of the survey is still not clear to you, please call Beth Morris in the Office of Health Policy at (502) 564-9592 or email betha.morris@ky.gov. It is important to complete this survey accurately by the deadline in order to be in compliance with licensing and Certificate of Need requirements. Once data have been received, edited, and published by this office, no changes will be made to the published report.